DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PARTS C AND D OVERSIGHT AND ENFORCEMENT GROUP

February 28, 2014

E-MAIL: Thomas.Wilfong@amerigroup.com

Mr. Tom Wilfong
Chief Executive Officer
AMERIGROUP Corporation
4425 Corporation Lane
Virginia Beach, VA 23462

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H3240, H4211, H5746, H5817, H5896, H6181, H6264, H7200, and H8991

Dear Mr. Wilfong:

On December 21, 2012, the Centers for Medicare & Medicaid Services (CMS) issued the final audit report to your organization for the above-referenced Medicare Advantage and/or Prescription Drug Plan contracts. The audit evaluated your organization's compliance with CMS requirements in the following areas:

1. Part D Formulary and Benefit Administration
2. Part D Coverage Determinations and Appeals
3. Part D Grievances
4. Part C Organization Determinations and Appeals
5. Part C Grievances
6. Part C Access to Care
7. Parts C & D Agent/Broker Oversight
8. Parts C & D Compliance Program Effectiveness
9. Enrollment and Disenrollment
10. Late Enrollment Penalty (LEP)

Your organization was afforded 90 calendar days from the report date to provide data and documents to CMS to demonstrate and attest that all of the deficiencies in the audit report were sufficiently corrected and not likely to recur. CMS reviewed your evidence of correction submission and also conducted a review to validate the implementation of required corrective actions and immediate corrective actions.

This notice is to inform you that based on the evidence provided by your organization and the validations conducted, you have corrected all conditions except:

The following conditions still remain from the audit report:

1. **Formulary and Benefit Administration, Formulary Administration, Condition iii.** - AMERIGROUP failed to properly effectuate a coverage determination leading to improper administration of the CMS approved formulary. This condition was not validated as corrected because the same condition was identified in 8 of 14 samples reviewed during the validation (FA-2, FA-3, FA-4, FA-6, FA-7, FA-8, FA-9, and FA-14).
2. **Formulary and Benefit Administration, Additional Findings, Condition ii.** - Coverage determinations resulting in Part B coverage were improperly effectuated by including parameters that are not consistent with Medicare Part B Local or National Coverage Determinations. This condition was not validated as corrected because the same condition was identified in 4 of 14 samples reviewed during the validation (FA-6, FA-7, FA-8, and FA-9).
3. **Formulary and Benefit Administration, Additional Findings, Condition iii.** - AMERIGROUP failed to correctly effectuate a Part B versus Part D coverage determination. This condition was not validated as corrected because the same condition was identified in 4 of 14 samples reviewed during the validation (FA-6, FA-7, FA-8, and FA-9).
4. **Part D Coverage Determinations, Appeals, and Grievances, Appropriateness of Clinical Decision-Making, Condition i.** - AMERIGROUP denial letters did not include adequate rationale or correct information specific to each individual case and did not clearly document next steps to obtain coverage or formulary alternatives. This condition was not validated as corrected because the same condition was identified in 2 of 13 samples reviewed during the validation (CDM-1 and CDM-7).
5. **Part D Coverage Determinations, Appeals, and Grievances, Appropriateness of Clinical Decision-Making, Condition ii.** - AMERIGROUP did not notify the beneficiary of its determination decision within the CMS required timeframe for the determination request. This condition was not validated as corrected because the same condition was identified in 4 of 13 samples reviewed during the validation (CDM-10, CDM-11, CDM-12, and CDM-13).
6. **Part D Coverage Determinations, Appeals, and Grievances, Appropriateness of Clinical Decision-Making, Condition iii.** - AMERIGROUP did not sufficiently document outreach efforts made to the prescribers/physicians to obtain the required clinical information needed to make appropriate decisions. This condition was not validated as corrected because the same condition was identified in 2 of 13 samples reviewed during the validation (CDM-1 and CDM-2).
7. **Part D Coverage Determinations, Appeals, and Grievances, Appropriateness of Clinical Decision-Making, Condition iv.** - AMERIGROUP was late in forwarding a determination to the Independent Review Entity (IRE). This condition was not validated as corrected because the same condition was identified in 4 of 13 samples reviewed during the validation (CDM-10, CDM-11, CDM-12, and CDM-13).
8. **Part C Organization Determinations and Appeals, Effectuation Timeliness, Condition i.** - AMERIGROUP failed to ensure that beneficiaries were notified of standard pre-service organization determination decisions. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (ET-1 and ET-4).
9. **Part C Organization Determinations and Appeals, Effectuation Timeliness, Condition iii.** - AMERIGROUP failed to ensure that beneficiaries were notified of the expedited pre-service organization determination decisions. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (ET-6 and ET-9).

10. **Part C Grievances, Dismissals, Condition i.** - AMERIGROUP did not forward cases to the independent review entity (IRE) with requests for dismissal timely (within 60 days of the request) when it did not receive waivers of liability by the conclusion of the appeal time frames. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (DIS-2 and DIS-3).

The following condition has not yet been validated related to Formulary Administration – Transition:

1. **Part D Formulary and Benefit Administration, Transition, Condition i.** - AMERIGROUP failed to provide multiple transition fills of a non-formulary medication to a long term care beneficiary during the transition period. This condition could not be validated until 2014. This condition could not be validated because CMS has to wait across plan years (i.e. from 2013 to 2014) in order for a universe to have an appropriate number of transition beneficiaries (new and continuing) to yield a suitable sample size.

The following new condition identified during the validation:

1. **Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making** - AMERIGROUP did not provide enough information for the enrollee to understand the reason their request was denied; the denial rationale was not written in a manner that an enrollee can understand in 4 samples tested during the validation. The primary cause of this issue is that AMERIGROUP has developed a system to automatically generate notices of denial. When this system populates the description field to explain the procedure code, the language is truncated. Without a full detailed explanation, the beneficiary is not completely informed of the reason for denial. Failure to include adequate and understandable information regarding the denial may impair the beneficiary's ability to mount an adequate appeal and could result in delay in/denial of care and/or financial hardship. (CDM-14, CDM-17, CDM-19, and CDM-20).

The following observation:

1. **Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making -** When AMERIGROUP denied a request for payment from a non-contracted provider, the remittance advice/notice did not provide a description of the appeals process. Failure to provide complete notifications regarding the denial of a request for payment may potentially cause financial harm to the beneficiary. AMERIGROUP should strengthen its controls to ensure that the remittance advice/notices contain the required information, including provider appeal rights regarding a denied payment request.

Your validation provided CMS with a reasonable assurance you are in compliance with program requirements tested during the audit. However, CMS will require heightened monitoring of the conditions and/or observations noted above to ensure Sponsor continues to implement effective correction. Your Account Manager will contact you to address these issues.

CMS is closing your audit.

CMS considers your compliance program's effectiveness to be essential in preventing, detecting and responding to potential non-compliance and fraud, waste, and abuse. Therefore, CMS expects your organization to continue monitoring the effectiveness of the corrective actions you have implemented and to continue to measure and improve the effectiveness of your compliance program. In addition, your Account Manager will continue to monitor and oversee your operations and compliance program to ensure that your organization is in compliance with all CMS requirements.

If you have any questions concerning this notice, please contact Mr. Darryl Brookins at 410-786-7542 or via email at Darryl.Brookins@cms.hhs.gov.

Sincerely,

/s/

Tawanda Holmes
Director, Division of Audit Operations
Medicare Part C and D Oversight and Enforcement Group

cc:
Michelle Turano, CMS/CM/MOEG
Joann Young, CMS/CM/PCOG (Audit Lead)
Anne McMillan, Account Manager, CMS/CMHPO/Region V
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